

01. Private Sector - Profit
02. Private Sector - Non Profit
03. Federal Gov't - Military
04. Federal Gov't - Non Military
05. State Gov't
06. Local Gov't
07. Self Employed
08. Other

10. Employer Tel. No.    -    -

11. Employer Fax    -    -

12. Employer Name & Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Maryland Pharmacy Permit #

14. No. of years active in your profession?

15. Last year of active practice?

16. Previous Residence Since Last Renewal

1. Maryland 2. Out of State ☐

17. Maryland Graduate ☐

1. Yes 2. No

18. Year of Graduation

19. Other States or Jurisdictions Licensed as a Pharmacist?

a.   b.

c.   d.

20. Licensed in another Profession? ☐

1. Yes 2. No

If yes, indicate the profession  
\_\_\_\_\_

SINCE YOUR **LAST REGISTRATION**: FOR THE FOLLOWING, CHECK THE BOX YES, OR NO NEXT TO EACH QUESTION.

- | YES                      | NO                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you been addicted to the use of drugs or alcohol with the result that your ability to practice your profession has been impaired? (You may respond no if you are currently in compliance with a contract with the pharmacist rehabilitation committee recognized by the Board.)  |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. (a) Has any State Licensing or Disciplinary Board, or a comparable body in the Armed Services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, or revocation?   |
| <input type="checkbox"/> | <input type="checkbox"/> | (b) Have you surrendered or failed to renew a license in any State?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Are there any outstanding complaints, investigations or charges pending against you in any State by any Licensing or Disciplinary Board for a comparable body in the Armed Services?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you had a physical or mental illness that currently impairs your ability to practice your profession?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you pled guilty, nolo contendere, or been convicted of, or received probation before judgment of any criminal act (excluding traffic violations)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you pled guilty, nolo contendere, or been convicted of, or received probation before judgement for a traffic offense involving the use of alcohol, drugs or controlled dangerous substances.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has any hospital or related healthcare institution or employer denied you privileges or employment, denied any application for privileges or employment, failed to renew your privileges or contract or limited, restricted, suspended, revoked, or terminated your privileges or contract for any reason related to your practice? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Have the conditions of your employment been affected by any termination of employment, suspension, or probation for any reason related to your practice?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Has a malpractice suit been filed against you or has a claim for damages been settled or awarded against you?   |

**ATTACH A DETAILED EXPLANATION FOR EACH QUESTION CIRCLED YES.**

I certify that I have earned the required hours of Continuing Education.

I affirm that the information I have given in answer to these questions are true and correct to the best of my knowledge and belief.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_